HIT Policy Committee Information Exchange Workgroup
Draft Transcript
March 24, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody and welcome to the Policy Committee's Information Exchange Workgroup. As a Federal Advisory Committee, there will be opportunity at the end of the call for the public to make comment. Just a reminder, workgroup members please identify yourselves when speaking.

Roll call: Micky Tripathi?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Judy Faulkner? Connie Delaney? Gayle Harrell? Am I hearing my own voice or are people saying yes? Is Gayle on? Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Latanya Sweeney? Charles Kennedy? Paul Egerman?

Paul Egerman – Software Entrepreneur
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jim Golden?

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Dave Goetz? Jonah Frohlich? Steve Stack?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Hripcsak? Seth Foldy? Jim Buehler? Walter Suarez?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Ross? Hunt Blair?

Hunt Blair – OVHA – Deputy Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Oestreich? Kory Mertz?

Kory Mertz – NCSL – Policy Associate
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Did I leave anyone off? All right, I'll turn it over to Micky.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Welcome, everyone, to the Information Exchange Workgroup. We've got a lot of people on today, which I really appreciate. A couple of things that we want to accomplish; we had a great in person meeting last week, or the week before, I'm already losing grasp of time, but I wanted to first of all thank everyone who participated in that. While it's always hard to go through an all-day session like that, I thought we retained great energy throughout and really appreciate everyone's engagement on that.

We've got a deck here that tees up what we wanted to go through today, and there are a couple of things. One is Kory and Claudia have drafted a letter, which would be the letter from the Information Exchange Workgroup to the Meaningful Use Workgroup in anticipation of their April 5th meeting to provide our recommendations on the recommendations that they put out for public comment. So we want to walk through that letter, make sure that we captured to all of your satisfaction where we believe we got consensus around some of the issues that we were able to tackle on that day. You may recall, we left some issues on the parking lot, so we wanted to go through that a little bit as well. Those were mostly in the area of, one significant one was medication reconciliation, and then there were some that were, as I recall, were recommendations that were genuinely new requirements, meaning that they didn't have a stage one legacy.

So for the ones that we did tackle—almost all of them were continuations of stage one requirements that either continued them or moved them to core or increased the objective of the measure but they did have some hook back into stage one. The ones that we decided that we would leave for the discussion on this call, and I believe we have a call next week as well, are the ones that are genuinely new, so we wanted to think about those as well. In general, I think those are the two things that we want to be able to get through here.

David, anything else to add, or is that your sense as well?

David Lansky – Pacific Business Group on Health – President & CEO
Yes, I have a couple of issues I want to put on our list, but I know that today may not be the time to get to them. One of them is, we had the Meaningful Use Workgroup call this week and the issue of the timing of stage two and stage three is coming up as a Policy Committee question. I'm wondering whether we should give some thought to whether potential changes in the timing of the program affects our thinking about the information exchange requirements, that's one. The second is this qualified entities discussion that we started, and I know we'll come back to, but maybe we can take this up as we look at the letter. But I was thinking that we didn't do a lot in our conversation to consider all the work we've done on provider directories and how that pertains to the qualified entities language and proposal. Those are the two things I want to somewhere put on our list.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Yes, I think those are both great points. I know there's some risk in doing this, but I'm wondering if there's a quick two sentence or three sentence summary of what the questions are related to timing.

Because I'm just wondering as we go through this maybe that's something that all of us want to keep in mind as we're thinking about that, if there is the potential for movement in certain directions with respect to that.

David Lansky – Pacific Business Group on Health – President & CEO
I don't have the detail in front of me. Paul Tang summarized three or four alternatives that the Meaningful Use subcommittee will make comment about and they come out of discussion that ONC and CMS are having about ... in response to the public comment .... I don't know—

Judy Sparrow – Office of the National Coordinator – Executive Director
David, I can send that document to the group.

David Lansky – Pacific Business Group on Health – President & CEO
Okay. Is there other ONC staff on who might be better at summarizing the state of the analysis than I am? I don't know who else is on the call. Is Claudia on?

M
No, Claudia's not with us today, and I, unfortunately, am not up to speed on that.

David Lansky – Pacific Business Group on Health – President & CEO
Okay. Well the two or three sentence version is there's consideration as to whether to extend stage one participation longer and shorten stage two, move the time frame structure of stage two so that the stage two requirements would not be employed for another extra year. Another opportunity would be to keep the timing, but change its stage if it was only a matter of adjusting thresholds, not adjusting functional requirements. There are a couple of other ... variants on those, but that's the drift of the discussion. We may have some opinion, given what we're hoping to see happen in exchange, whether those alternatives are better or worse from what we're looking toward. So if Judy shares the document maybe we can come back to that on our next call.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay.

Deven McGraw – Center for Democracy & Technology – Director
I do think it would be important for us to weigh in on this because I think a lot of us were disappointed in the lack of exchange requirements in stage two. So any sort of timing adjustment that plays off of just what exists in stage one in particular would have a significant impact on how far we could push on exchange in stage two and is of great concern to me.

David Lansky – Pacific Business Group on Health – President & CEO
Yes, good point, Deven. Thanks.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
One comment on that. I think one way of thinking of strategizing perhaps in terms of stage two requirements is if we separate the requirements related to quality metrics and some of the other requirements that do not necessarily imply an exchange, and then separate those from the exchange requirements, that might be a way to organize the sequence. Perhaps look at pushing back those requirements that don't relate to exchange and bringing forth some of the requirements that relate to exchange so that during stage two the initial set of requirements relates to exchange and the later set of requirements relate to the quality metrics and some of the other things that don't deal with exchange.

David Lansky – Pacific Business Group on Health – President & CEO
Walter, I appreciate that. That's a good framework for us to think about as we look at, if we have time on the next call to come back to that. We might want to think about how we advocate for certain components that we think are more time critical to stay in the more aggressive timeline.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO

Exactly, okay.

David Lansky – Pacific Business Group on Health – President & CEO
Good. Thanks, Micky.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Great, thank you. I think those are great points. Judy will circulate that and then I think we can have that as one of our key agenda items for the next call. If we could just advance a slide here, so we want to first I think review the draft comment letter to the workgroup and all of you have that as a separate Word document. Hopefully you've had a chance to take a look at it, but if not I think we can quickly go through it and if anyone has any comments, questions along the way, please just weigh in and we'll take them up as we go through it. It's not that long. It's a five page document with a high level synthesis of where we came down. I think Kory did his best to capture where we seem to have left off as a consensus, but there may be certain elements that aren't quite what people remember, so I think it's important for us to go through it item by item as quickly as we can.

In terms of the review of the proposed objectives, incorporating lab results as structured data, the workgroup concurs with the proposed stage two objective, I think that was the consensus that we came to there. On the summary of care record, you may recall there was some conversation, and I think consensus that we had, about trying to start to build in a requirement for electronic transmission. So not only did we want to see the creation of the standardized summary of care records out of the systems, but wanted to move to a glide path or a ramp up to full electronic exchange and we recommended having 30% of these be transmitted electronically. Any comments on that? That builds up to the stage three objective of there being 80% of them in terms of 80% of encounters and then all of them electronic transmission, I believe is how that reads.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
No, it doesn't seem to read that way, I think.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Is it 80% electronic?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Well, I think if we want to ramp up the stage two—stage one is 50%, so stage two should be maybe 80%, provide summary of care record for more than 80% of transmissions. Then 30% of those would be ones that would be expected to be done electronically. That's one way of thinking of it, because right now what it reads is we're moving it to core but keeping the same level to 50%.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, my recollection is that we had a little bit of discussion about that but we thought that it was appropriate to move it to core but keep it at the same level. But what we wanted to do was up the ante with respect to the requirement that we start transmitting them electronically.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Because when you look at the proposed stage three, stage three moves it to 80% and then all of them done electronically. So in some respects it might be better to expect that in stage two there will be summaries provided to 80% of them, and then 30% of those 80% would be done electronically. Then in stage three, you move to 80% everything electronic.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Let me just ask the process point. Walter, are you saying that you think we have not documented correctly the consensus that we reached at the meeting, or you're just suggesting that this is what we seem to have agreed to, but you're now suggesting that maybe we should re-think that, or you can't remember?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO

I can't remember.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Fair enough.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
What I was arguing is that this is not adding up to 80%. This is saying that we're still keeping everything at 50% but now out of that 50% we're requiring 30% of those to be done electronically. Maybe I understood it wrongly, but I thought you said that this adds up to 80%.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
No. I was saying that stage three gets us to—

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Oh, okay.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
—... so that up to 80% of—

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
—... would all have been electronic, I believe is—

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Okay, then I was misunderstanding what you said. I'm fine with the way it is. I just want to make sure that we realize that the jump to stage three is increasing both the total of instances where summaries need to provided and then making them all electronic. So it's a big jump, I suppose, to stage three then. I'm fine with the numbers there, the way they are basically.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Does anyone else have any thoughts or concerns on this one?

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
Is it 30% of all the transactions that have to be electronic, or is it 30% of the 50% that are being transmitted?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
The way it reads is it's 30% of the 50%.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
What—

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
... in the way that it reads.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I would read it as it's 30% of whatever percent you do and at a minimum that has to be 50%. But if you do 80%, it has to be 30% of the 80%. If you create a structured summary of care for 80%, then 30% of the 80% would have to be transmitted electronically. That's how I'm reading that. Is that how other people are reading it?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, I think that's right. You have to do at least 50%—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
—and at least 30% of those have to be done electronically. But you can 80%, still 30%. You can do even more than 30% electronically.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, absolutely. It's not a ceiling, yes.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
Okay, thank you.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, so if there aren't any more comments on that one, on electronic prescribing you may recall that there is an electronic prescribing requirement for eligible professionals in stage one but not for hospitals in stage one, as I recall. The recommendation was for it to be in stage two that it would now be a stage two requirement for hospitals as well. But the issue that we had with it was that it basically would have to equal the eligible professional and the hospital's requirements, whereas, I think it was the workgroup sense that we ought to be pushing more aggressively on the eligible professional side. So we recommended increasing the thresholds for the eligible professionals to 70% and 90% respectively in stage two and stage three, and keeping the hospitals one at 40% and 70%. That's the first issue.

The second was retaining the exemption for controlled substances in the calculation, but with an eye toward recognizing that in stage three we may be prepared for ending the exemption, which would also suggest that we want to be able to start to lay that foundation by including two-factor authentication as a certification criteria for stage two. I know Deven thought that this accurately reflected where we landed. I, myself couldn't remember the exact details, so I want to make sure that everyone agrees that this is the right phrasing for this part of it. I know the Privacy and Security Tiger Team is going to be taking this up, and I remember we had that conversation wanting to be able to give the headroom to that tiger team to be able to develop the specific recommendations that it's going to come up with.

Deven McGraw – Center for Democracy & Technology – Director
Yes. Thanks, Micky. We're not quite done with those conversations, but I can't foresee that we wouldn't come out with a recommendation for certification that would allow the systems to accommodate the DEA rules on authentication.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, but certainly for the Information Exchange Workgroup it doesn't seem like we could go any further with that without jumping out ahead of where the tiger team is, which I don't think any of us really wants to do at this stage.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Just to clarify, this is not the second statement about the two factor authentication. It's not intended to create an expectation at all that ePrescribing will be required to be done using two factor authentication, right? At this point only the ePrescribing of controlled substances done under DEA rules requires two factor authentication; everything else, 95% of all the ePrescribing doesn't really require two factor authentication.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, this is not speaking to the policy of when you would have two-factor authentication. It's just saying that the systems need to be able to accommodate two-factor authentication.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
So in stage three we intend to remove the exception, that's just—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
That would just mean that they get included in the denominator when you're doing your calculation.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Okay, I understand. All right, thanks.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Unless there are any other comments there, performing a test of the HIE I think was one where we had a lot of conversation. In part, as I recall there were a couple of dimensions of conversation that we had. One was this makes sense generally as a separate requirement if we had a whole bunch of specific transaction type requirements like summary of care record exchange, ePrescribing, lab results, and a whole bunch of other things, didn't a summing of all of those basically add up to this, so was this really redundant to have this. But there was certainly conversation about the interpretation of what this was supposed to get at because there were conversations that this was about something which was fundamentally different, which was to say it was setting the stage for beyond push type transactions, to speak colloquially, to query response type of exchange.

It is fair to say that there was no clear agreement among the workgroups as to one or the other? Which I think led us to really say that we would need to clarify the purpose of this objective before leaving it in as is, that without that clarification it was really hard to interpret what it was trying to accomplish. We had some specific recommendations about defining some specific key terms, bidirectional connection, health information exchange, a qualified external provider, and then certainly that last question about whether the policy infrastructure is there to support the robust exchange that would be envisioned.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
A quick comment on this one. I really think that if an entity or an eligible provider professional is expected to meet meaningful use stage one and then meet the meaningful use stage two criteria, by virtue of that requirement they will be meeting the expectation of conducting at least one health information exchange. I continue to believe that this is not needed and that this is just creating more confusion of saying well, how come if I'm expected to meet all these other requirements at least one, if not more of those make me meet this point of performing a test of HIE. So, is there any eligible professional or hospital that in any circumstance would not be meeting the performing of a test of HIE by virtue of meeting this stage two criteria already? It's impossible to think of one.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I almost wonder whether we want to sharpen this language to say that because of the questions that we continue to have, we have the meeting and I think we still continue to have, that as currently stated we believe it's not satisfactory because of this question. If it is the former, but what we're suggesting, Walter, is that it could be redundant if one read it one way if it is supposed to be about a query type of transaction. Then that would need to be clarified and that we could ask the question of whether the infrastructure is really there to support that kind of thing and if that's fair. But listed as it is right now, it's entirely unclear what it's supposed to accomplish.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Micky, I would say that if the EPs are pushing care summaries, receiving structured lab data, pushing electronic prescriptions, I would say I'd still continue to question why we even need this. Whether it's clear or not is less important to me than whether it's even necessary. So I remain in that camp to say that they should probably just drop this, not because it's not important, but because all the other individual metrics are much more specific for specific desired outcomes and this is just confusing and not value adding.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Seth Foldy – Wisconsin – State Health Officer

There was some language about this regarding the, if I'm remembering right this is the one that talks about your core referral network or some such term. In other words, they were defining a community in which exchange is occurring. I know that language got my attention because an interesting question for us is, for example, whether or not the case managers of a local health department are included or excluded from that community. That was the new aspect, it seemed to me, is it was saying, one, you will use it and we will define use as meaning to a certain minimum sense of a community. Does that make sense?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I think it does make sense. I guess that's somewhat related to the specific question we have here about who is a qualified external provider.

Seth Foldy – Wisconsin – State Health Officer
I must admit, I'm a little lost about that question probably because of some of the discussions of this group. It may relate, but I'm not sure I know.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
The actual criteria says connect to at least three external providers in the primary referral network.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
This whole requirement, even though it's about performing, or at least the title says performing a test, the requirement tells me more about connecting either to at least three external providers or to an established health information exchange and have an ongoing bidirectional connection.

Seth Foldy – Wisconsin – State Health Officer
The term "qualified provider" as it's being used in our workgroup, does that refer then to a qualified healthcare provider to document that you're exchanging with somebody, or a qualified HIE? I guess I was interpreting it as the latter.

James Golden – Minnesota Dept. of Health – Director of Health Policy Division
I kind of agree. That's a good question. I had that same question. I too interpreted it as an HIE provider of some kind, and it might be helpful to clarify which of those we mean. Just hearing this conversation, a lot of this seems very reminiscent of the long discussion that we had at the last meeting. I like this recommendation that I think that the first bullet point identifies exactly what Walter and Steven are saying. As it stands, as it's drafted, I don't think that the objective of it is very clear. I don't really understand what the purpose of it would be. I was actually in a camp that was assuming that this was to help tie to some of ONC's various programs, whether it would be the 3013 activities, whether it would be some of their other activities in supporting exchange such as Direct or Connect or those. So in addition to the things that are here, I think one question that I would just like to see is if they plan to keep this to have a more explicit discussion of how this relates to other ONC activities to support exchange, not only 3013, but some of the other activities that they have going on. If it doesn't tie to any of that, it seems to me that the first bullet point accomplishes what Walter and Steven are saying.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I think in terms of process we probably have a question here. One is that we either decide per Steven and Walter, and perhaps others, that we just don't like this and we recommend getting rid of it. The other would be that we recommend clarifying it. It does leave open that once clarified we may disagree with it, and so we would want to weigh in on it once it's been clarified.

Deven McGraw – Center for Democracy & Technology – Director
I can't say that I'm the sole word on what the Meaningful Use Workgroup was thinking here, but having participated in a number of discussions I think that it was just put in as a way to advance from merely testing in stage one to actually exchanging in stage two without thinking that there might be other ways to

accomplish exchange with providers outside of your own practice or integrated delivery networks through the other meaningful use objectives like sharing a care coordination summary or ePrescribing or pushing lab data, etc. I think if we have a viable proposal about advancing exchange that's related to specific categories, I think it would be very well received. But again, that's one person's opinion.

Paul Egerman – Software Entrepreneur
As I look at this, to me that first bullet "Clarify the Purpose of the Objective," it's damning the whole thing. If we don't understand why it's there, that says something very important. It just seems to me, picking up on what Deven said, is the sense I'm having from this discussion is that we'd rather be affirmative on other information exchange activities, that's the way to go, and it includes this objective, which seems awkward, seems difficult to implement.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

David Lansky – Pacific Business Group on Health – President & CEO
Micky, I agree with Paul's comment and Deven's. I wonder if the burden on us should be, not this minute but soon, to go further with these questions that you've asked for clarification on. And actually propose a framework or a language of vocabulary for talking about this which is outcomes or functionally oriented, and says, okay, we think there are these five or nine elements in the short term to operationalizing the concept of HIE. The first three can be achieved given the existing expectations of meaningful use, like lab push, and separate out, for example, push versus query and then within those talk about some of the specific functions that are high priority in the next two, three years. Then say, okay, against this check list we think the following ones can be accomplished through the existing types of requirements of meaningful use, but these other ones may need some other kind of test or incremental activity. We haven't really put forward a framework that would allow the Meaningful Use Group to be more—rather than just push it back to them and say, figure it out, we should probably try to offer something that frames it a little better.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, I think that's a great suggestion. Perhaps we can take that up off line and then come back to the workgroup on the next call with the proposed framework and something that would be more constructive for the Meaningful Use Workgroup to engage on.

Deven McGraw – Center for Democracy & Technology – Director
That would be great.

Hunt Blair – OVHA – Deputy Director
I think that's a great suggestion. Thank, you, David, for that clarity.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, great. The next three are the public health ones, and I think that those in general were the ones that we had a lot of discussion about whether, essentially questions of whether the infrastructure was prepared for these types of transactions. So just taking them one by one, the electronic immunization reporting, the language was somewhat amorphous, I think, because it talks about some immunizations. It wasn't clear about the delineations. We recommended that the language be revised in the way that you see there. Because it's a mandatory test, some immunizations are submitted on an ongoing basis in accordance with applicable law and practice. We were concerned about the ability of the infrastructure to handle bidirectional exchange in stage three, which would mean about being able to consume immunization data and wanted to flag that right now there didn't seem to be a path to having that infrastructure in place by the stage three timeline.

Seth Foldy – Wisconsin – State Health Officer
I had promised to bring back to the group what has been happening in discussions around the latter topic, the issue of if there's going to be bidirectional exchange how it might occur. There has been an expert

panel that met, but its final report is not available yet. Actually, let me first ask by ascertaining, how public is this meeting? Is this a work meeting of the workgroup exclusively at this point?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
No, this is a public meeting.

Seth Foldy – Wisconsin – State Health Officer
So consideration of a variety of possible transport mechanisms that might enable bidirectionality are under consideration. I think what might be of great interest to the workgroup is, is there likely to be a specification for those that would both be well enough defined and also implementable in a time frame such that the necessary certification requirements might be included in stage three meaningful use regs? That's how I interpret the problem. There's also the issue of will there be immunization registries covering enough of the country to make this a significant goal? But I believe the answer to that has since already been answered in the affirmative. We don't have universal immunization registry coverage, but they were deemed important enough that people had to contribute data to them in stage one anyway. So I don't think we have to worry about is there enough immunization exchange to make this worthwhile. But we do have to worry about will there be a practical solution that will be offered by a reasonable, first of all, that will be clear enough to go into stage three regs?

And second of all, will public health be ready to avail itself? I actually think the language that is stated in the letter addresses the second point, which is, if immunization registries don't continue to get some financial help, they may not be able to bring this solution to the table. But the language as stated doesn't answer the first question, which is, will there be a standard method that ONC and CMS will be able to recommend? Not wanting to go into detail about private discussions, or discussions that haven't been fully digested for public consumption, I do have some optimism that there will be a methodology that will be reasonably cost effective and probably test implemented by stage three that would enable the EHR to pull a view of the patient's total immunization record. That is, those submitted by all providers, for viewing in the EHR. And also guidance related to what are missing vaccines that might need to be made up. I hope that gives the committee more information about the status of things here, and I'll try and answer questions.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
As I recall in the conversation, I think it related to the syndromic surveillance as well, there was concern expressed about just in principle not wanting to make something a certification requirement for standards that are under development but not yet developed and in the market in some substantial way.

Seth Foldy – Wisconsin – State Health Officer
For stage two, that certainly makes total sense. For stage three, I guess the question is what kind of wiggle room do we want given that, although we're pointing a direction we're not yet forcing people to go final.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Seth, I just wanted to understand a couple of points. I think there are several different transactions related to immunization. One is, many of the providers send data to the immunization system, that's the one that is at the moment the requirement. The second one is, me as a provider sent a query to the immunization system and get a response back.

Seth Foldy – Wisconsin – State Health Officer
Right, either a pull or a push, yes.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
This is one is a pull. I'm sending a query and receiving a report back. But you were talking about a third one, which is the immunization registry system sends a query to a provider to get data—

Seth Foldy – Wisconsin – State Health Officer

No, I'm sorry. The question then becomes, you have a patient sitting in front of you. You have seen the immunization registries and your own record's assembly of all of the shots this person has received. Then the question is, what is that person missing? As you may know, the clinical logic for that is getting more and more difficult as we offer more and more shots at differing intervals. So most immunization registries currently in a Web interface, that is a Web site interface, a browser interface, are providing advice saying it looks like this kid needs the following shots today. So it is, in a sense, a type of clinical decision support, but originating from the registry with its combined records. That's the third level of possible directional communication. It's called "forecasting." I don't know why they chose that word in the registry community. Does that make sense, Walter?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I'm still trying to figure out the transaction there, in the forecasting one.

Seth Foldy – Wisconsin – State Health Officer
It would be a message that says—

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Sent by whom?

Seth Foldy – Wisconsin – State Health Officer
That's the question. The registry could send a message saying, given what we see in our registry your patient is deficient in vaccines. An alternate model would be for the EHR clinical decision support to have the logic built in. But either way, whether it's the registry or the EHR, they would want to use the combined data of shots, those that were in the EHR and those that were in the registry.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Okay.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I would just observe, I think that the whole outcome is laudable and praiseworthy, but I almost think sometimes we go a little bit ahead on the clinical decision support piece. The first step in a transitional thing here would be just to get the comprehensive information in front of the eyes of the clinician, who would then exercise human judgment. Then downstream, I know it's hard because if you're going to design a system de novo you'd like to design it to do what you eventually want it to do in the first place, but that's kind of complex since we don't have any exchange happening right now largely on these things. I guess I would just speak for focusing on getting the information in front of the clinicians and as time progresses we can evolve to having hopefully clinical decision support integrate those variable sources and make it work better.

Seth Foldy – Wisconsin – State Health Officer
And leaving open the question of how.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Correct.

Seth Foldy – Wisconsin – State Health Officer
Again, I'm a little awkward because I'm speaking for a community of public health providers but they're not in my shop. What I can say is there are many in that community who say we offer this functionality today, that is to say nurses today are checking the immunization registry and getting this advice today and so if over time registries stop being the portal through which people are seeing this information, we should definitely try and make sure that functionality also exists tomorrow. Just because we're backing away from the get on the Web site and look model doesn't mean that you want to give up that level of functionality. I'm hoping that makes sense to people, that it might represent a clinical and public health step backward.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

As it currently reads right now, the only bidirectionality, if we're going to call it that, is for the specific case of well-child, adult visit, providers review records via their EHR, correct?

Seth Foldy – Wisconsin – State Health Officer
I believe that's the language.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
But that's in stage three.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes, that's stage three, right. So our recommendation right now, as currently stated, is one, to sharpen the question about the law. Because the original language said if accepted and as required by law and we change that to in accordance with applicable law and practice recognizing that in some places it is the law and in some places it's not, so we want to clean that up. That's the first comment on stage two. Then in stage three I guess it just strikes me that right now the way the letter reads is that we have some concerns about whether the stage three infrastructure is going to be there. It would seem to me that, expressing the concern, we either want to remove the language because we're so concerned about it, or I would think we would want to leave an out that says, "if the infrastructure is available" or something like that. But now it seems that it's sort of in this in between stage that is a little bit unsustainable.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
It seems to me that the second statement in stage three that says "During well child visits providers review the Immunization Information System records via their EHR" needs to be even tightened a lot more. Not just adding the statement, Micky, that you said about if the infrastructure is ..., the way it reads it gives the impression that "During all well child, adult visits providers review all IIS records," and then there's no positioning or percentage or if you can do it kind of a thing. So the language needs to be tightened up quite a lot more so that it doesn't give the impression that now I have to do all my child visits just going around and checking IS records.

Seth Foldy – Wisconsin – State Health Officer
It does say well child visits.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
All the well child visits, but it's sort of like giving the impression that it's 100%. There's no percentage.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Seth Foldy – Wisconsin – State Health Officer
Good point. I guess what I would say is that the capability and the standards for viewing immunizations from other practices by pulling that information into the EHR from the immunization registries is likely to be available. The number of registries that implement that capability may be somewhat dependent on funding. The language that's written might lead people to say don't go there, which I think would be a defeat, would be kind of a shame, because I think we should aim to, at the very least be able to see the immunizations, and I concur with Walter's point that the proportion of visits is a reasonable issue to address.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Seth, you're speaking to the public health infrastructure side of this, right? Does that also mean that we would then need to recommend that there is a corresponding certification requirement that the EHR can generate such a query?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
And receive the response?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes, and consume response, exactly.

Seth Foldy – Wisconsin – State Health Officer
That does seem to be the past practice from stage one, that there's typically an understanding of how the EHR industry is to approach this in a standardized way.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So you're saying that, I believe that the certification requirement is just about sending immunization data according to a standard, 2.3.1, I think, out of my system to an immunization registry. It doesn't say anything about my generating a standards-based query from my system and then being able to consume what comes back.

Seth Foldy – Wisconsin – State Health Officer
Yes, 2.3.1 and 5.3.1 for your sending, correct.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I thought what Seth was pointing to is that that seems to be the practice, so if there's a requirement on a meaningful use stage one, let's say, there's a corresponding expectation of some certification criteria. If the intent is to have a requirement about not just submitting data to an immunization registry but now also performing a query and receiving a response, then there would be a need to establish some certification criteria for EHRs that they will have that capability as well, separate and aside from the ability to submit data. If I understand correctly, Seth, what you were saying.

Seth Foldy – Wisconsin – State Health Officer
I guess I assumed that that is what would happen. Otherwise, I suppose you have doctors and hospitals incented to do something using tools that may or may not be able to do them.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I think that's where we get into this practical question that I personally don't know the answer to of whether the standard right now encompasses that capability or if it's mature enough to be able to make that a requirement.

Seth Foldy – Wisconsin – State Health Officer
I agree with the one speaker that spoke a few seconds ago, I think the current ONC standard does not specify the required methodology for EHRs. But if it was my belief that there would be new certification standards that would likely occur with stage two and new certification requirements that likely would occur with stage three.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
If I may jump in, because if we see these as stage three, maybe it's important to mention in the comments perhaps that there will be a need to establish some certification criteria for EHRs to handle the bidirectional capabilities expected in the stage three metric, but it's not something that needs to be established right away. It's an issue that is important to raise but not to resolve, because it's not something that is definite for stage three. The expectation in stage three, there will be a new NPRM, I suppose, and new regulations in 2014 laying out the ground for stage three and concretely establishing the metrics for stage three and then the certification criteria for stage three. I don't know that we need to resolve that specific question of certification here, just to mention it as it will be important to look, at the appropriate time, at the certification criteria needed to enable EHRs to handle bidirectional exchanges with IIS'.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right. I think the question, though, as a workgroup that we do need to be able to provide some perspective on is whether we think that it is reasonable to assume that that could be a ubiquitous standard by stage three, right?

Seth Foldy – Wisconsin – State Health Officer

Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I don't know myself what we've done in other types of transaction areas in the way of precedent. Have we taken the leap in some other areas?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think this ties back to the ONC S&I framework, for example, where we're here identifying a potential gap of standards or a need for a defined standard. There is a machinery, an infrastructure of activities under the S&I framework and there are other ONC activities that help fulfill those gaps by working with the SDOs to define those standards. If we are here already in 2011 identifying that there will be a need to establish a standard and to create a certification criteria for EHRs to meet that standard for bidirectional communication then the SDOs will be on point, I guess, or will be warned, fair warning that there needs to be that standard be developed. But I think we're just here identifying potential standards gap and a need to have that gap fulfilled by 2014 or something like that.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Seth Foldy – Wisconsin – State Health Officer
I concur.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, does it make sense on this one for—we want to recommend that a threshold be put in, some type of objective measure, I don't know if we have thoughts on what that ought to be, in stage three, that would be the first time imposed. So typically you're trying to have a ... so you would have it at a relatively, not something like 80% or 90% or 100%, you'd have it at some lower threshold. That seems to be one thing that's coming out of this. The second, I wonder we want to add that caveat, which I think is consistent with, it might have even been in the stage one, or I forget where it is, the caveat that a provider is not held accountable for this if the infrastructure isn't in place for it to happen in his or her particular state. Then perhaps in the language have the discussion point that in order for this to happen it does assume that robust standards that could translate into certification requirements would happen by stage three.

Seth Foldy – Wisconsin – State Health Officer
Right. I concur with Walter that I think it would be useful for us to point out to the Meaningful Use Workgroup that for this stage three objective as written to occur some certification language is going to be needed. I would be in favor of taking out the caveat about spending. It is true for everything in meaningful use that if you don't have the money, some people won't be implementing. But I don't think that that should dissuade us from moving forward to being able to see other immunization records from the immunization registry. I won't even say anything about getting guidance about those immunization records. I'm happy to remain silent on that as a workgroup, given that it is so important that we be able to at least see the immunization records previously obtained elsewhere. I'm sorry. So I agree with the first thing you were saying.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
That's on the certification. So the question was do you agree with language on the need for corresponding certification?

Seth Foldy – Wisconsin – State Health Officer
Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
The second point was actually adding a caveat that would essentially be the escape hatch that says that if you're in a state that doesn't have the infrastructure, then you're not going to be held accountable for this one.

Seth Foldy – Wisconsin – State Health Officer
I wouldn't add that because that's just the way the law is written. In other words, it doesn't add anything to the current regulations and law. That would be true of any of the public health and some of the others as well. I won't argue vociferously about it. I'll just say that that's the way the law is written, at least for stage one. If it's available you do it, and if it's not available you don't have to do it.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
By the law you mean the meaningful use requirement?

Seth Foldy – Wisconsin – State Health Officer
Exactly, the regulation, yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Then the third one was, it was the certification. I'm sorry, I just lost –

Seth Foldy – Wisconsin – State Health Officer
I think it was perhaps striking the language about concerns that public health won't be ready. I think if we have timely certification rules and the method worked out many immunization registries will be ready to perform this bidirectional communication.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I wasn't suggesting that. I would like to hear what other people think about that. I guess my personal thought is I thought that, at least for me, and I thought I heard from a number of other workgroup members that the public health infrastructure question is a very large question mark. Do others have thoughts on that, questions? It really is not a specific recommendation. It's about whether to put that as a part of our discussion of the issue. Okay. Well, hearing no other concerns about that, I would suggest we move on, on this. I know what the other one was, we certainly want to recommend that there be an objective, correct, a measure, and I don't know if there are thoughts about specifying a particular threshold.

Seth Foldy – Wisconsin – State Health Officer
It doesn't sound like that would necessarily be the expertise of the IE Workgroup. I think recommending that there be a threshold and leaving it up to meaningful use is okay with me.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Is that okay with others?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, I think that – you're just talking about the thresholds for stage three?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Stage three, yes.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think it will be difficult to—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
At this point.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I think that's right. Stage three is kind of directional anyway. So moving ahead, the syndromic surveillance: On that one, I actually would suggest to everyone that we actually were more firm on a conclusion on this one than the wording suggests here. That I thought that it wasn't just that we

expressed caution about moving eligible professional requirements to core for stage two, but that we actually recommended not doing that, and I believe we're even questioning why it was even a part of stage one.

Seth Foldy – Wisconsin – State Health Officer
I know that one point that I raised is sometimes it's a little unpredictable to leave something an option if it's only a list of one option, if there aren't other options. So that might be the reason for the soft language. If both immunization reporting and electronic—no, but it won't be. It won't be in year two because electronic laboratory reporting to public health will also be an option. So it will have a partner to choose from. I'm sorry. I will retract my statement. There will be two options in stage two, and this won't be left as the single optional element.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I guess we'll get the report of the labs, but do other people have the same recollection that I do, that we actually had recommended not having the eligible thresholds included in this, in stage two?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
In syndromic surveillance, absolutely.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, as I remember that conversation the bias wasn't strong around it and the standards weren't there. It was sort of a very unclear area at this point.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I would replace "strong concern" rather than "caution." "The workgroup expresses strong concerns about ...." Seriously, I think when we're talking about syndromic surveillance there is a lot of question about what would ambulatory settings do with respect to syndromic surveillance, and right now it's mostly and primarily almost exclusively limited to hospital emergency room visits.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
So I would recommend, just to sharpen it, that we say what I thought we came to, which is that it's not that we expressed caution or even strong concern, we recommend that eligible professionals not be subject to this in stage two.

Seth Foldy – Wisconsin – State Health Officer
Not be subjected to it as a requirement—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
... as core for stage two.

Seth Foldy – Wisconsin – State Health Officer
I did want to offer a slight adjustment to what we've said. There are communities, Boston is an excellent example, that both obtains and uses this ambulatory information and they do gain insights from it.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Do you mean ambulatory or do you mean—?

Seth Foldy – Wisconsin – State Health Officer
Including ambulatory, yes, in Boston and in some other jurisdictions they both require and use ambulatory encounters to be reported. So it's not that there is no use, but whether or not there's likely to be an implementation guide in time for stage two, I believe that is a very reasonable open question, and therefore, at least for technical reasons, it is reasonable to view this as an option.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I totally agree. So we can strengthen that language. Moving to the reportable labs, I believe that the current language here had the language that said that for eligible professionals. So for hospitals it moves stage one to core and then for eligible professionals it is a new requirement and it says that it ensures that the eligible professionals are required to ensure that reportable lab results and conditions are submitted to public health agencies, either directly or through their performing labs.

Seth Foldy – Wisconsin – State Health Officer
Yes. Here, I remember our discussion as ending slightly differently than the letter. We recognize that there's some ambiguity created by the use of an "or" clause, but I believe we supported an "or" clause for two reasons. One, physicians themselves are doing more and more reportable lab work in their practices and they are still mandated to report. But two, many of the reports will continue to come from the clinical lab partners of the clinicians. So, I didn't think that we were prepared as a committee to say that physicians shall not report, but that they did need to be prepared to report reportable lab work. If the lab is the only place that that lab work is done, it can come from the lab. If the doctor's office is the only place that that lab work comes from, it can come from the doctor's office. If they do both, it can come from both.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
I think that the concern that we had was the statement that eligible professionals are required to ensure that their lab is doing the reporting.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
This is an overreach, in my mind. This is creating a requirement that has nothing to do with EHRs and everything to do with public health reporting requirements, which I absolutely agree with the concept that eligible professional physicians need to report those to public health, and I'm completely in support of that. It's just that this is not the right vehicle to establish a requirement that eligible professionals ensure that their labs send the data. That has nothing to do with EHR or meaningful use. It's an overreach of expectations in my reading of this.

I think it's appropriate to expect that the menu option that EPs will report lab results to public health agencies that they receive from the lab. There has to be a ... that they receive from the lab. We talked about this at that meeting, where there is an expectation up above or some earlier expectation about providers being able to receive lab results in structured form up to a certain level, I forget, so that is already an expectation. So incorporating lab results as structured data, that's going to be moved to the core, but only where results are available. So expecting in this particular case that EPs would report lab results to public health agencies as a menu option is fine. I think dropping the rest would be my recommendation, because again this is not the right vehicle to enforce the requirement that labs need to send the data.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Do others have thoughts on this? Certainly, there's the question of it's labs that are done in your office, to Seth's point, then obviously that is the source, that's the only source of the information, so there's absolutely a requirement to report that.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
But it's already in the state regulations and other regulations.

Seth Foldy – Wisconsin – State Health Officer
As I'm thinking about this, the problem with having doctors and labs both report is you start getting duplicate reporting, which we have to then manage. I'm wondering about perhaps instead of mandating that doctors get their laboratory partners to report on their behalf, that should we consider doctors will report any reportable labs performed in their office and thus not create a double reporting stream and double reporting burden?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

First of all, if you're talking a large physician practice, so I have a 150 physician practice in the city I practice in and they have a lab in their building, then they're going to be a licensed laboratory providing outpatient laboratory services and then they would be expected or required, like any other dedicated laboratory, to report their data. If you're talking about a doctor in an office doing CLIA waived point of care testing—a rapid strep test, a rapid urine pregnancy test, things like that—I think we're overreaching and going too far to require that they report those things from the doctor's office as structured data. Because I think what will end up happening is there will be physicians who ultimately say, well, forget the convenience to the patient, I can't justify all this extra work. So they'll just have to go to an emergency department or I'll write them a prescription and they can go to a laboratory and get the test.

I think that at this stage that information would be captured in their EMR because they would document the information in their admitted note, or however it's done. But I think we'd be better to focus on laboratories reporting laboratory data and not going to the doctors having to do that, so that we also don't have the doctors having to go and manually re-enter all sorts of labs that they may have gotten from a lab. I just think it will have unintended and perverse consequences that I don't think we'd like to have.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Steve, the implication of what you just said for the recommendation would be that we remove, I think, the whole EP section from the stage two.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I guess yes from the standpoint that having them report, I think, like we mentioned in the in person hearing, that most of us rely on the labs to report. I'm in an emergency department and we do tons of STD tests, and we as the providers, and I'm in an institutional setting so it's different, but I don't think we report that stuff in general. We rely on the laboratory to report all positive tests as required by law.

Seth Foldy – Wisconsin – State Health Officer
I think the problem here is that the eligible hospital language refers to hospital labs, but the stream from those ambulatory labs is just as important to have electronically reported. I'm talking about the larger entities, not the CLIA waived tests. The current stage one language is silent on those.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Right, but isn't that covered by law elsewhere? ... like meaningful use is the lever to get a lab to report.

Seth Foldy – Wisconsin – State Health Officer
Reporting is covered, but moving them to standardized electronic reporting consistent with the hospital lab practice would not be.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
The only problem is that meaningful use doesn't apply to ambulatory labs or labs that do tests for ambulatory providers, but the state laws apply to those labs. Whenever a lab receives an order for an STD test or an AIDS test and it's positive, the lab is required to report that back to the public health agencies. That's a state law, for the most part.

Seth Foldy – Wisconsin – State Health Officer
I think the goal is to start mobilizing more standardized electronic laboratory reporting rather than all of the old methods.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Sure, but the meaningful use, it will be like the provider somehow requiring the lab that the lab sends the data to the public health agency electronically using a standard.

Seth Foldy – Wisconsin – State Health Officer
I guess this is the way I see it happening in practice. I think the points raised are all valid, and I was wrestling with this myself, but I am an ambulatory provider and I am attesting that my clinical lab sends specimens to the public health agency using the approved ONC standard. In the case of the stuff coming

from the lab, that's what you're attesting to. Of course what this does is it creates a competitive pressure on laboratories to fall in line with ... under the rules of this now hospital laboratory practice. I don't think it's going to be a huge issue because in fact hospital labs tend to be the ones who are less sophisticated about electronic laboratory reporting than are larger commercial labs, which are often the source of testing from mandatory practices. So if you follow my model through, you're just saying that the doctor's attesting to the fact that yes, I use a lab that electronically reports, yes/no.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I don't disagree that that's a desirable outcome. But I think it's a derivative use of the meaningful use program to try to leverage the provider community to then leverage the lab provider community to do something that's desirable. I think that that is a derivative application of meaningful use and I think it puts just a different sort of expectation on the provider community. It's not that it's undesirable. It's just that I don't think that it's what meaningful use is ideally designed for.

Seth Foldy – Wisconsin – State Health Officer
Yes. I'm thinking about your alternative of the ambulatory lab versus the doctor using CLIA waived tests, and one thing I am sensitive to is that there are some tests like gonorrhea and Chlamydia that may move into the quick kit in a CLIA waived realm. But one option might be to say ambulatory providers who are CLIA certified laboratories must report by electronic laboratory reporting. So the waived testers are waived and the CLIA certifieds are reporting.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Again, I guess my thought would be that if I were using the 80/20 rule in this general conceptualization I'd focus more on trying just to have the labs do their—and I know meaningful use is not going to do this, but—to report their data electronically to the public health community. And not try to bite off this particular piece of the apple, certainly for stage two, because I think it has in some ways it goes down a rabbit hole. Particularly if you put it on the optional list, one concern I have is that we definitely have to be careful that we don't look at the optional menu items. That the list of optional menu items, that so many of them are not attainable that it really becomes a parking place for things that it's really hard for people to find things to pull off it that they can meaningfully do.

But I think we're not going to solve this, I don't think, at this point. I think that of course if someone does a CLIA waived test in their office they're going to, for medical legal reasons, document that in their EMR. It won't be structured data perhaps, but it will be documented in their visit note that they did a rapid strep test and it was negative. I think down the road it may be that if there's CLIA waived chlamydia or gonorrhea tests—although we don't even do those in the emergency department where I am. They all go to the lab—then over time the doctor, if they're the only one who provided it and it's done in their office and there's no confirmatory test, then I imagine that state law will require them to report it. At which point if the EMR captures that structured data it may be reasonable down the road to require that they in fact do exactly what you're hoping they do.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Are there other workgroup members who have a view on this? I feel very uncomfortable, and I was trying to think if there's any precedent in any of the other meaningful use requirements of trying to do what is suggested here. Which is basically to impose on the physicians an attestation that another organization is doing something, in effect using meaningful use to try to create policies in another area that's not really even related to electronic health records. I also get very concerned just about the credibility of meaningful use in general if we start to put these kinds of things on them, because of how that will be perceived in the provider community.

Hunt Blair – OVHA – Deputy Director
Micky, I agree. I have those same concerns and think that it really is not an appropriate use of the meaningful use structure.

Carl Dvorak – Epic Systems – EVP

I would also, I guess, lend a bit of voice of support for what Steve Stack is trying to say. And that is, I think as committee members and people trying to drive policy—no one person experiences the full weight of meaningful use, but I think what we're starting to see is the customers now are beginning to understand what the full weight is. I think we just have to be judicious on what we stack on that stack of, Steve Stack, as you go through life trying to actually implement this. If we go too far I think you run the risk of destroying the program. I think we ought to be judicious and hit what we think are the critical things, the things that will set the tone and the pace for the long term future, not necessarily try to stack every single thing one might imagine can be interesting or useful on at the wrong time. So I think Steve's on an interesting path and I think it's one that we should be thoughtful about at all times as we continue into the next few phases of this.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think we're dealing with two separate issues here, as I see it. One is, this is the first point, is whether the expectation should be that EPs, eligible professionals, report lab results that they have received from the lab and then report those lab results electronically through the EHRs to public health. That's issue number one. Should the lab results be reported by the EHR of an eligible professional, or should it always come from the lab for those that are required to be reported, because otherwise it creates what Seth was referring to, which is a duplication of records. That, in my mind, is the number one issue, separate from the second issue, which is the one I raised earlier. I think Steve articulated very well, the overreaching of this regulation or this expectation in this stage two of making eligible professionals be agents to require some compliance of an electronic submission of lab results by external labs through a meaningful use regulation.

So I wanted to separate the two issues because I think we need to address both of them. Do we consider that lab results should be reported from the EP EHR? Then secondly, which I think we're all agreeing, there should not be an expectation that through the meaningful use program eligible professionals become agents to enforce non-covered entities to report electronically to public health. I think on the second point we're all in agreement that the stage two component of requiring eligible professionals to be agents of enforcement should be dropped. I think the first question still lingers out there, which is should lab results be reported from the EP EHR system?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
We're getting very short on time here. I'm not sure we're going to be able to resolve this one here. I guess one question would be why do we have them coming out of the EP system if they're coming from the labs?

Deven McGraw – Center for Democracy & Technology – Director
I think it's a legitimate question to raise, and I also think we may have a little bit more membership from the public health community on IE than may be present in meaningful use, although I can't say I've done the head count. But I think it's worth raising the question.

Seth Foldy – Wisconsin – State Health Officer
There are some arguments for including the provider in the stream of reporting, in that inevitably the provider is also asked to give other information related to reportable conditions. In other words, the stream today is the lab reports and then sooner or later somebody has to call up the provider's nurse and get a bunch more information. In this case we would be leveraging certification requirements that are already in existence for the EHR. In other words, to have an EHR it has to be capable of spitting out that 2.5.1 ELR message, so it is probably not a very major burden on the provider.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Actually the requirement is to incorporate lab results, not send out lab—

Seth Foldy – Wisconsin – State Health Officer
What I'm talking about is the requirement on hospitals is also to send to public health and the requirement for certification of an EHR, if I'm not mistaken, would apply to both of them. In other words—

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I see. That's a good point, yes.

Seth Foldy – Wisconsin – State Health Officer
So that the EHRs that ambulatory providers are buying today are, if certified, theoretically have the capability to send.

M
The criteria would only apply if they have an objective, so I don't think in this case where there is an objective on EPs that it would be built into ambulatory EHRs, it would be built into inpatient EHRs now, though.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Oh, then, yes, exactly. Okay.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, we're coming to the end of our time here and we need to save a little bit of time for the public comment. So clearly we're going to, on our next call, continue this conversation. We have a specific recommendation about a new requirement that we would recommend for hospitals to be required to send structured lab result data as a part of the meaningful use requirement. So we will take that up along with the rest of the agenda that we're going to hope to get to today on our next call, and also the timing question that David had raised earlier in the call.

Seth Foldy – Wisconsin – State Health Officer
I would also say that I don't think we've addressed the question of eliminating the other reportable condition language or causing it to be separated from laboratory, which is how I had interpreted the outcome of the last meeting. I just want to return to that at the next meeting if we can.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
Yes, I was going to point that out. Thanks, Seth. Yes, the third item on this ELR reporting, which is the last statement in the letter, Micky, which is, "The workgroup also recommends removing the requirement of reportable conditions from these objectives for stage three."

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Yes.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO
I think that's an important one to come back to.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay, so we will start again at the next meeting on this "submit reportable lab data" part of the letter.

Seth Foldy – Wisconsin – State Health Officer
Thank you.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Okay. Judy, I think we're ready for the public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, can you check and see if anybody wishes to make a comment to the workgroup?

Operator
We do not have any comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Okay, just a reminder, the next call is on March 30th. Thanks, Micky.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO
Thank you. Thanks, everyone.

Public Comment Received During the Meeting

1. Most pathologists are "eligible professionals" too, so why not have a different requirement for pathologist EPs versus other EPs in the area of lab reporting?